UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

KINERET(anakinra)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

_____Minimum age requirement**:** 18 years old

- Diagnosis of severe Rheumatoid Arthritis
- History of treatment failure, incomplete response or intolerance to Methotrexate, and at least one other DMARD or second line drug (azathioprine, sulfasalazine, leflunomide, penicillamine, hydroxychloroquine, etc.) Kineret, Enbrel, Remicaid are mutually exclusive. Patient may only be on one of these agents at a time.
- The number of swollen joints, must be 6 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- The number of tender joints must be 9 or more. **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Rheumatology consultation within the last 60 days.
- May not be given with other biologic agents such as Interferon, experimental medications or combinations.

AUTHORIZATION:

Initial prior is for 12 weeks.

RE-AUTHORIZATION:

Subsequent PA is for 12 months if the patient has at least 20% **DOCUMENTED** improvement in 4 of the following 6 areas: tender and swollen joint count, patient and or global assessment of disease activity, pain, acute phase reactants. Yearly letter updating response to Kineret.